State of Wisconsin
Department of Employee Trust Funds

Department of Employee Trust Funds
801 W. Badger Road
P. O. Box 7931
Madison, WI 53707-7931

# Contract By Authorized Board

**Commodity or Service:** Third Party Administration of Dental Benefits

**Contract No./Request for Proposal No:** ETE0020
Amendment #2 dated August 23, 2017

Authorized Board: Group Insurance Board (GIB)

**Contract Period:** January 1, 2018 through December 31, 2019 with the option of renewal for one (1) two (2) year period

1. This Contract is entered into by and between the State of Wisconsin, Group Insurance Board (GIB) hereinafter referred to as the "Board" and the State of Wisconsin, Department of Employee Trust Funds (ETF) hereinafter referred to as the "Department", and between the Delta Dental of Wisconsin, Inc. hereinafter referred to as the "Contractor", whose address and principal officer appears on page 2. The Department is the sole point of contact for this Contract.

2. Whereby the Department of Employee Trust Funds agrees to direct the purchase and the Contractor agrees to supply the Contract requirements cited in accordance with the State of Wisconsin standard terms and conditions and in accordance with the Contractor's proposal dated March 30, 2015, hereby made a part of this Contract by reference.

3. In connection with the performance of work under this Contract, the Contractor agrees not to discriminate against any employees or applicants for employment because of age, race, religion, color, handicap, sex, physical condition, developmental disability as defined in s.51.01(5), Wis. Stats., sexual orientation as defined in s.111.32(13m), Wis. Stats., or national origin. This provision shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The Contractor further agrees to take affirmative action to ensure equal employment opportunities. The Contractor agrees to post in conspicuous places, available for employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of the nondiscrimination clause.

4. Contracts estimated to be over fifty thousand dollars ($50,000) require the submission of a written affirmative action plan. Contractors with an annual work force of less than fifty (50) employees are exempted from this requirement. Within fifteen (15) business days after the award of the Contract, the plan shall be submitted for approval to the Department. Technical assistance regarding this clause is provided by the Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931, 608.266.2586, or via e-mail at ETFSMBProcurement@etf.wi.gov.

5. The Contract Amendment #1 dated January 12, 2017 increases the administrative fee for the per contract per month (PCPM) fee up $.05 (five cents) which increases the total fee to $1.14 (one dollar and fourteen cents) effective January 1, 2018. Exhibit A and Exhibit B are attached with revised dates that correspond to the contract period covered by this Contract Amendment #1.

6. This Contract Amendment #2 dated August 23, 2017 includes Exhibit C Delta Dental Uniform Dental Benefit Changes for calendar year 2018 as approved by the Board on May 24, 2017.

7. The parties agree that if there is another renewal of this Contract covering the period for the final two (2) year renewal option (January 1, 2020 through December 31, 2021), the administrative fee for the per contract per month (PCPM) fee will be $1.14 (one dollar and fourteen cents).

8. For purposes of administering this Contract, the Order of Precedence is:
   A). The Contract with Delta Dental of Wisconsin, Inc. including Exhibit A Dated June 10, 2015 and Exhibit B Dated June 16, 2015;
   B). This Contract Amendment #2 dated August 23, 2017 including Exhibit C Delta Dental Uniform Dental Benefit Coverage for calendar year 2018 as approved by the Board on May 24, 2017;
   C). The Contract Amendment #1 dated January 12, 2017 including Exhibit A dated January 12, 2017 and Exhibit B

dated January 12, 2017 which replaces the Exhibit A dated June 10, 2015 and the Exhibit B dated June 16, 2015;

D). the RFP dated February 20, 2015;
E). Delta Dental of Wisconsin, Inc. Response to Questions Dated May 7, 2015;
F). Delta Dental of Wisconsin, Inc. Response to Questions Dated April 7, 2015;
G). Delta Dental of Wisconsin, Inc. Cost Proposal Dated March 30, 2015; and,
H). Delta Dental of Wisconsin, Inc. Proposal Dated March 30, 2015.

**Contract Number & Service:** **ETE0020** Third Party Administration of Dental Benefits

Amendment #2 dated August 23, 2017

| **State of Wisconsin**<br><br>**Department of Employee Trust Funds** | **Contractor to Complete** |
|---|---|
| By Authorized Board (Name)<br>**Group Insurance Board** | Legal Company Name<br><br>Delta Dental of Wisconsin, Inc. |
| By *(Name)*<br><br>**Michael Farrell** | Trade Name |
| Signature<br>DocuSigned by:<br>Michael Farrell<br>4581098061742482... | Taxpayer Identification Number<br><br>39-6094742 |
| Title<br>**Chair**<br>Group Insurance Board | Company Address *(City, State, Zip)*<br><br>2801 Hoover Road<br>Stevens Point WI 54481 |
| Phone<br><br>608.266.0301 | By *(Name)*<br>David Peterson |
| Date *(MM/DD/CCYY)*<br>10/6/2017 | Signature<br>DocuSigned by:<br>David C. Peterson<br>1F843BF98B66445D... |
| | Title<br>Vice-President, Sales & Marketing |
| | Phone<br><br>715.343.7618 |
| | Date *(MM/DD/CCYY)*<br>8/24/2017 |

# Exhibit C Delta Dental Uniform Dental Benefits

## UNIFORM DENTAL BENEFITS (CERTIFICATE OF COVERAGE)

**Please read the following information carefully for your procedure frequencies and provisions.** All dental benefits are paid according to the terms of the Master Contract between the Health Plan and PBM and Group Insurance Board. The Uniform Dental Benefits are wholly incorporated in the Master Contract.

This is a list of Uniform Dental Benefits and is based upon the Current Dental Terminology © American Dental Association. Codes are provided as a reference and may be subject to change; plans may substitute alternative codes to provide essentially equivalent coverage.

## Definitions

**Dental Plan Administrator:** The third party administrator responsible for providing the Uniform Dental Benefit plan under the Group Insurance Board's program. Delta Dental of Wisconsin is the current Dental Plan Administrator for the Uniform Dental Benefit plan.
**Dental Plan:** Means all benefits, limitations, and exclusions included in the Uniform Dental Benefit Certificate.
**Dental Provider:** Means a dentist or any other person or entity licensed by the state of Wisconsin, or other applicable jurisdiction, to provide one or more Dental Plan benefits.
**In-Network Dental Provider:** A Dental Provider who has agreed in writing by executing a participation agreement to provide or direct dental care services, supplies, or other items covered under the policy to participants. The Dental Provider's written participation agreement must be in force at the time of such services, supplies or other items covered under the policy are provided to the participant.

Note that there are no out-of-network benefits available under this Dental Plan.
**No payment will be made for a benefit that is not listed.**

- Your benefits are based on a calendar year. A calendar year runs from January 1 through December 31.
- During the first year a person is insured, benefits begin on the effective date and continue through December 31 of that year.
- Covered procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- X-ray films, periodontal charting and supporting diagnostic data may be requested for health plan review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.
- Note that Uniform Benefits may provide coverage for some oral surgery. Refer to your medical benefits certificate for additional oral surgery coverage.

**Limitations**
The following services **are limited** under this Dental Plan:

- Oral Exams limited to two per year.
- Full Mouth or Panoramic x-rays limited to once every 60 months.
- Bite wing x-rays limited to two sets per year.
- Cleaning of teeth limited to two times per year.
- Fluoride treatment allowed only for a child under age 19, limited to two times per year.
- Sealants allowed only for a child under age 16, and must be applied to non-restored, non-decayed first and second permanent molars, limited to once per tooth per lifetime.

- Routine pediatric dental services as required under federal law.

****Special note on fillings:** On anterior (front) teeth You will have 100% coverage subject to Your benefit maximum for both amalgam (silver) and composite/resin (tooth colored) fillings. On posterior (back) teeth, you have 100% coverage subject to your benefit maximum for amalgam (silver) fillings only. If you have a composite/resin (tooth colored) filling on a posterior tooth, you will be responsible for the difference between the amount your provider charges for an amalgam and a composite/resin filling.

**Exclusions**

The following are **not covered services** under this Dental Plan:

1. Services for injuries or conditions that can be compensated under Workers' Compensation or Employer Liability laws.
2. Services or appliances started prior to the date the patient became eligible for coverage under the State of Wisconsin's Group Health Insurance Program's Uniform Dental Benefit.
3. Prescription drugs, pre-medications or relative analgesia charges for anesthesia in connection with covered oral surgery procedures.
4. Preventive control programs; charges for failure to keep a scheduled visit with a dentist; charges for completion of forms; charges for consultation.
5. Charges by any hospital or other surgical or treatment facility, or any additional fees charged by a dentist for treatment in any such facility.
6. Charges for treatment of, or services related to, temporomandibular joint dysfunction.
7. Services that are determined to be partially or wholly cosmetic in nature.
8. Appliances, restorations or procedures for increasing vertical dimension; for restoring occlusion; for correcting harmful habits; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth, unless restoration is needed to restore normal bodily function; for temporary dental procedures; for implantology techniques or for splints, unless necessary as a result of accidental injury.
9. Replacement of lost or broken retainer.
10. Treatment by other than a Dental Provider, his or her employees, or his or her agents.
11. Dental care injuries or diseases caused by war or act of war, riots or any form of civil disobedience; injuries sustained while committing a felony; injuries intentionally inflicted; injuries or diseases caused by atomic or thermonuclear explosion or by the resulting radiation.
12. Claims not submitted to Dental Plan Administrator within 12 months, or if later, as soon as reasonably possible, from the date the procedure was provided.
13. Dental procedures in cases where, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained.
14. Procedures and services not specifically provided under this Certificate of Coverage and procedures and services excluded by Dental Plan.
15. Any oral surgical procedures not specifically listed as a covered benefit or for which coverage exists under Uniform Benefits.

| **Key Contract Provisions** | | **Covered Services (Examples)** |
|---|---|---|
| | **In-Network Provider** | |
| **Deductible:** | $0 | |
| **Annual Benefit Max:** | $1,000 per participant | |
| **Diagnostic / Preventive:** | 100% | Routine Evaluations<br>X-rays<br>Fluoride |
| **Restorative:** | 100% | Fillings |

| | | |
|---|---|---|
| **Periodontic:** | 80% | Limited to Periodontal Maintenance |
| **Adjunctive Services:** | 80% | Local Anesthesia |
| **Orthodontia:** | 50% (children only) | |
| **Ortho Lifetime Max*:** | $1,500 per participant | |

*Lifetime max does not reset when you change health plans

# Diagnostic/Preventative:

**Routine Oral Evaluation** - exams are limited to two per year.
Note that comprehensive exams are not done multiple times in a year.

- D0120 Periodic oral evaluation.
- D0145 Oral evaluation for patient under three years of age.
- D0150 Comprehensive oral evaluation – new/established patient or a patient who has been absent from dental care for more than three years; included as one of the two exams per year.
- D0160 Detailed & extensive oral evaluation.
- D0180 Comprehensive perio evaluation – new/established patient; included as one of the two exams per year.

**Limited Oral Evaluation**

- D0140 Limited oral evaluation - problem focused.

**Complete Series or Panoramic Film:** limited to one (either D0210 or D0330) once every 60 months.

- D0210 Intraoral - Complete including bitewings.
- D0330 Panoramic radiographic image.

**Other X-rays**

- D0220 Intraoral periapical first radiographic image.
- D0230 Intraoral periapical additional radiographic image.
- D0240 Intraoral occlusal radiographic image.
- D0250 Extraoral first radiographic image.
- D0260 Extraoral each additional radiographic image.

**Bitewing Films -** limited to two sets per year.

- D0270 Bitewing single radiographic image.
- D0272 Bitewings two radiographic images.
- D0273 Bitewings three radiographic images.
- D0274 Bitewings four radiographic images.
- D0277 Vertical bitewings 7 to 8 radiographic images.

**Prophylaxis (Cleaning) and Fluoride:**
**Prophylaxis:** D1110, D1120

- D1110 Prophylaxis (cleaning) – Adult; limited to twice per year.
- D1120 Prophylaxis (cleaning) – Child; limited to twice per year.

**Fluoride -** limited to twice per year up to age 19.

- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride.

**Sealant**

- D1351 Sealant - per tooth; limited to once per lifetime up to age 16, first and second molars only.

**Space Maintainers -** limited to primary teeth lost prematurely

- D1510 Space maintainer fixed unilateral.
- D1515 Space maintainer fixed bilateral.
- D1520 Space maintainer removable unilateral.
- D1525 Space maintainer removable bilateral.
- D1550 Recementation space maintainer.
- D1555 Removal of fixed space maintainer.

**Restorative:**

**Amalgam Restoration**

**see note on fillings on page 79 of this certificate.

- D2140 Amalgam filling - one surface.
- D2150 Amalgam filling - two surfaces.
- D2160 Amalgam filling - three surfaces.
- D2161 Amalgam filling – four/more surfaces.

**Resin Restorations**

**see note on fillings near the top of this certificate.

- D2330 Resin filling - one surface anterior.
- D2331 Resin filling - two surfaces anterior.
- D2332 Resin filling - three surfaces anterior.
- D2335 Resin filling – four/more surfaces anterior.
- D2390 Resin Crown anterior.
- D2391 Resin filling - one surface posterior; benefits limited.
- D2392 Resin filling - two surfaces posterior; benefits limited.
- D2393 Resin filling - three surfaces posterior; benefits limited.
- D2394 Resin filling – four/more surfaces posterior; benefits limited.

**Miscellaneous Restorative:**

- D2940 Sedative filling; limited to once per lifetime per tooth.
- D2951 Pin retention per tooth; limited to once per tooth.
- D2999 Unspecified restorative procedure by report.

**Periodontic:**

- D4910 Periodontal maintenance. Coverage is limited to two procedures per one benefit period in addition to routine cleanings.

**Oral Surgery:**

Please note that eligible oral surgical procedures are covered under Uniform Medical Benefits when furnished by a covered Dental Provider.

**Adjunctive Services:**

- D9110 Emergency treatment/palliative.
- D9210 Local anesthesia not in conjunction with operative or surgical procedures.
- D9215 Local anesthesia used in conjunction with operative or surgical procedures.
- D9220 General anesthesia – 30 minutes.
- D9221 General anesthesia – 15 minutes.
- D9230 Nitrous oxide sedation.
- D9241 Intravenous sedation analgesia – 30 minutes.
- D9242 Intravenous sedation analgesia – 15 minutes.
- D9610 Therapeutic parenteral drug, single administration.
- D9612 Therapeutic parenteral drugs.
- D9910 Application of Desensitizing.
- D9911 Apply desensitizing resin.
- D9930 Treatment of complications.
- D9999 Unspecified adjunctive procedure.

**Orthodontic Services** - limited to age 19, 50% coverage.

- D8010 Limited orthodontic treatment of primary dentition.
- D8020 Limited orthodontic treatment of transitional dentition.
- D8030 Limited orthodontic treatment of adolescent dentition.
- D8040 Limited orthodontic treatment of adult dentition.
- D8050 Interceptive orthodontic treatment of primary dentition.
- D8060 Interceptive orthodontic treatment of transitional dentition.
- D8070 Comprehensive orthodontic treatment of transitional dentition.
- D8080 Comprehensive orthodontic treatment of adolescent dentition.
- D8090 Comprehensive orthodontic treatment of adult dentition.
- D8660 Pre-orthodontic treatment visit; may also be billed out as any combination of D0330, D0340, D0350, and D0470.
- D8680 Orthodontic retention (removal of appliances, construction/placement).
- D8690 Orthodontic treatment (alternative billing to a contract fee).
- D8999 Unspecified orthodontic procedure, by report.
- D9310 Consultation – diagnostic services other than requesting provider.